Missouri Department of Social Services

MO HealthNet Division

Program Integrity Report

State Fiscal Year 2007

January 2008

INTRODUCTION

Senate Bill No. 577 passed by the 94th General Assembly in 2007 mandates as part of 191.909.2 that the Department of Social Service report to the General Assembly and the Governor the results of provider and participant fraud reviews each year. This report covers state fiscal year 2007.

The Department of Social Services, MO HealthNet Division (MHD) is responsible for conducting provider and participant reviews to determine compliance with MO HealthNet program policy and regulations. The Program Integrity (PI) Unit within the MHD performs this function.

Case reviews of MHD providers that result in suspicion of healthcare fraud (relating to allegations of violations under sections RSMo 191.900 – 191.910) are referred to the Office of Attorney General (AGO), Medicaid Fraud Control Unit (MFCU). Case reviews of MHD participants that result in suspicion of healthcare fraud are referred to the Department of Social Services, Division of Legal Services (DLS). This report includes data available to the Department of Social Services; the Attorney General's Office will report on the performance on the Medicaid Fraud responsibilities assigned to it under the law.

MO HealthNet PROGRAM INTEGRITY PROCESS OVERVIEW

Minimizing, fraud, waste and abuse and assuring the integrity of the Mo HealthNet program requires a variety of complex methods and cooperation across agency lines. The methods focus on a continuum of concerns from prosecution of criminal fraud to ensuring that the state pays no more than its fair share of the cost to care for Mo HealthNet participants. Generally speaking,

- **Waste** is defined as the expenditure of healthcare funds carelessly or needlessly and the unintentional misuse of fund through inadvertent errors.

- **Abuse** is defined as incidents or practices inconsistent with sound medical or business procedures.

- **Fraud** is defined as an intentional deception or misrepresentation that results in an unauthorized benefit or payment. Fraud can be perpetrated by service providers and by recipients.

By law, MO HealthNet is the payer of last resort. This means that any medical cost incurred on behalf of a MO HealthNet participant is recoverable (or billable) to any other payer that may have responsibility for the participant's health care costs (private insurance policies, Medicare, etc.) or from other resources that may be available to the participant for his or her medical needs (settlement payments and court awards, workers compensation, estate, etc.). The MHD Cost Recovery Unit is responsible for recovering the cost of health care from other payers. This unit works with the Attorney General's Financial Services Division to file legal claims against participants' funds in estate and tort cases. The MHD Cost Recovery Unit is also responsible for the Health Insurance Premium Payment (HIPP) Program through which MHD will pay for private insurance coverage for MO HealthNet participants when it is cost effective to do so.

The MO HealthNet Program Integrity Unit is responsible for monitoring all aspects of MO HealthNet program compliance. This unit conducts post payment reviews, provider audits and uses automated systems that are programmed to detect suspicious billing and service utilization patterns. When provider or participants are found to be misusing or abusing MO HealthNet benefits, the Program Integrity Unit has the authority to pursue administrative sanctions against providers and "lock-in" recipients to specific providers. The Program Integrity Unit initiates administrative recovery of the cost of any benefits wrongfully claimed.

When the Program Integrity Unit discovers fraudulent activities, referrals are made to the Department of Social Services' Division of Legal Services (DLS) or to the Attorney General's Medicaid Fraud Control Unit. The DLS is responsible for investigating and prosecuting fraud perpetrated by MO HealthNet participants and cooperates with local prosecutors who pursue these cases. The Attorney General's Medicaid Fraud Control Unit is responsible for investigating and prosecuting fraud perpetrated by MO HealthNet providers and can either work with local prosecutors or pursue prosecution itself.

The following table categorizes claims as appropriate, wasteful, abusive or fraudulent and summarizes the parties and processes for appropriate remedy.

Table 1. Summary of Mo HealthNet Program Integrity Responsibilities

	- - - Continuum of Mo HealthNet Claims - - -			
	Appropriate	**Wasteful**	**Abusive**	**Fraudulent**
Nature of Claim	*Medically necessary*	*Unnecessary expenditure of state funds*	*Unsound medical or business practice*	*Intentional wrongdoing*
Responsible Unit	*MHD Clinical Services*	*MHD Cost Recovery MHD Program Integrity*	*MHD Program Integrity*	*DSS Legal Services AGO Medicaid Fraud Unit*
Processes/Tools	*MMIS, CCIP, prior authorization/Smart PA, CyberAccess, managed care, etc.*	*TPL identification, estate and tort recovery, compliance reviews*	*Compliance reviews, automated expenditure surveillance of*	*Accept MHD referrals, investigation, prosecution*

SECTION 191.909 REPORTING REQUIREMENTS

The following section of this report lists each reporting requirement in bold followed by the MO HealthNet Division's response.

Section 191.909.2 (1)

The number of MO HealthNet provider and participant investigations and audits relating to allegations of violations under sections 191.900 to 191.910 completed within the reporting year, including the age and type of cases

The Department Social Services, Division of Legal Services (DLS) conducts investigations into suspicion of participant health care fraud. DLS investigated 280 participant cases during state fiscal year (SFY) 2007.

The Office of Attorney General, Medicaid Fraud Control Unit is responsible for provider investigations relating to allegations of violations under sections RSMO 191.900 to 191.910 and will report its performance separately.

Section 191.909.2 (2)

The number of MO HealthNet long-term care facility reviews

Long-term care facility reviews involve program integrity staff reviewing claims submitted by the long term care provider to determine if the on site records and charts support the services billed to MO HealthNet Division. During 2007, the MHD Program Integrity Unit conducted four Long Term Care Facility reviews. The reasons for the reviews and outcomes are listed in the following table.

Table 2. Long Term Care Facility Reviews

Long Term Care Facility	Reason for Review	Outcome
Facility 1	Overpayment Validation	Overpayment validated and recovered
Facility 2	Investigative Review	Recovery of $7,126.98
Facility 3	Investigative Review	No errors found
Facility 4	Investigative Review	No errors found

The MHD Institutional Reimbursement Unit (IRU) conducts additional fiscal auditing of long term care facilities' cost reports to ensure accuracy of nursing facility cost reporting. While the number fluctuates slightly, there are approximately 500 nursing facilities participating in MO HealthNet at any given time. Institutional Reimbursement conducts audits on a cycle. In 2007, IRU completed 194 audits.

Section 191.909.2 (3)

The number of MO HealthNet provider and participant utilization reviews

The MHD Program Integrity Unit conducted a total of 2,049 reviews of MO HealthNet providers and participants during SFY 2007. Of the 2,049 reviews competed, 431 were provider reviews and 1,618 were participant reviews. Please see Table 3 for data related to outcomes and amounts collected.

Section 191.909.2 (4)

The number of referrals sent by the department to the attorney general's office

The MHD Program Integrity Unit referred 26 providers with suspicion of health care fraud to the Office of Attorney General, Medicaid Fraud Control Unit during SFY 2007. The MHD Program Integrity Unit referred 68 participants with suspicion of health care fraud to the Department of Social Services, Division of Legal Services during SFY 2007. Please see Table 3 for the data on investigations conducted and concluded during SFY 2007.

Section 191.909.2 (5)

The total amount of overpayments identified as the result of completed investigations, reviews, or audits

Table 3 Summarizes overpayments and collection opportunities identified by the Mo HealthNet Division's Cost Recovery and Program Integrity Units and by the Department's Division of Legal Services for State Fiscal Year 2007.

Section 191.909.2 (6)

The amount of fines and restitutions ordered to be reimbursed, with a delineation between amounts the provider has been ordered to repay, including whether or not such repayment will be completed in a lump sum payment or installment payments, and any adjustments or deductions ordered to future provider payments

The MHD Program Integrity Unit does not have the authority to order fines or restitution. The MHD Program Integrity Unit establishes the overpayment and requests repayment from the provider in accordance with the state regulation,13 CSR 70-3.030(6). If the provider fails to issue a check within the time allotted or establish a repayment plan, the amount is recovered by MHD from the future claims submitted by the provider. Please see Table 3.

Section 191.909.2 (7)

The total amount of monetary recovery as the result of completed investigation, reviews, or audits

The DSS MHD and DLS collections and costs avoided for SFY 2007 are summarized in Table 3 below. These figures include the results of third party liability collections by the MHD Cost Recovery Unit. The Office of Attorney General, Medicaid Fraud Control Unit will separately report on its collection performance. Please see Table 3.

Table 3. MO HealthNet Investigations and Cost Recovery 2004 - 2007

DSS MHN Program Integrity and Cost Recovery (provider focused)			
Fiscal Year	**Cost Avoidance**	**Cost Recovery**	**Total**
2004	$ 84,708,463	$ 38,035,985	$122,744,449
2005	$ 90,904,620	$ 41,084,920	$131,989,540
2006	$123,377,373	$ 63,289,433	$186,666,806
2007	$142,884,088	$ 54,060,109	$196,944,197
DSS MO HealthNet/Welfare Investigation Unit (recipient focused)			
Fiscal Year	**Number of Investigations**	**Cost Recovery**	**Total**
2004	249	$ 993,669	$ 993,669
2005	241	$ 1,880,286	$ 1,880,286
2006	282	$ 2,129,369	$ 2,129,369
2007	280	$2,088,342	$ 2,030,313
DSS Reinvestigation Savings (one time)			
Fiscal Year	**Cost Avoidance**	**Cost Recovery**	**Total**
2005	$67,500,000		$67,500,000
2006	$108,100,000		$108,100,000
Grand Totals			
Fiscal Year	**Cost Avoidance**	**Cost Recovery**	**Total**
2004	$ 84,708,463	$39,029,655	$123,738,118
2005	$158,404,620	$42,965,206	$201,369,826*
2006	$231,477,373	$65,418,802	$296,896,175*
2007	$142,884,088	$56,090,422	$198,974,510

*Includes one time cost avoidance savings due to increasing the rate of eligibility reinvestigation to 100% over the 05-06 fiscal years.

Section 191.909.2 (8)

The number of administrative sanctions against MO HealthNet providers, including the number of providers excluded from the program

The 323 administrative sanctions against MO HealthNet providers, including 73 providers excluded from the program. The following are examples of regulatory sanctions as found in 13 CSR 70-3.030(4):

- Termination from participation,
- Suspension of participation,
- Suspension or withholding of payments to provider,
- Referral to peer review committees,
- Recoupment from future provider payments,
- Transfer to a closed-end agreement,
- Attendance at provider education sessions,
- Prior authorization of services,
- 100% Prepayment review,
- Referral to state licensing board,
- Referral to appropriate federal or state legal agency,
- Retroactive denial of payments, and
- Denial of payment for any new admission to a SNF, ICF or ICF/MR.